**TEXAS HIV MEDICATION PROGRAM (THMP)**
**FUZEON MEDICAL CERTIFICATION FORM**

**(TO BE COMPLETED BY PHYSICIAN)** **Texas HIV Medication Code (if known)** _____

The information on this form is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information on this form will be kept strictly confidential by the Texas Department of Health. Personal identifying information is never released.

**PATIENT INFORMATION**

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone # (  ) _____

Date of Birth: _____/_____/_____ Social Security Number: _____
Month Day Year

*****This form is intended as a supplement to the standard THMP Medical Certification Form and should be submitted only in circumstances when Fuzeon (enfuvirtide) is being requested for your patient. *****

**1) PLEASE BE SURE TO ATTACH THE FOLLOWING DOCUMENTS TO THIS FORM – INCOMPLETE REQUESTS WILL HAVE TO BE RETURNED FOR COMPLETION:**

a. **A copy of the patient's most recent CD4+ count results**
b. **A copy of the patient's viral load test results, from within 12 weeks of this application date, indicating ongoing HIV replication (>1,000 copies/ml)**
c. **A copy of the patient's resistance testing results, from within 12 weeks of this application date, indicating that the patient's virus is susceptible to a minimum of two antiretroviral agents**

**2) Has the patient failed previous antiretroviral regimens that have included protease inhibitors and non-nucleoside reverse transcriptase inhibitors?**

_____ **Yes** _____ **No**

**3) Proposed optimized background regimen (in addition to Fuzeon)** _____

_____

**4) In order to assess the effectiveness of Fuzeon, we would like to obtain follow-up CD4 and viral load data on enrolled patients. May we contact your office by phone for this data at q 3-month intervals?**

_____**Yes** _____ **No**

**If yes, person in your office to contact:** _____

**Best day/time to call:** _____

**If contact via email is preferred, list email address:** _____

PHYSICIAN SIGNATURE: _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ DATE_____/_____/_____

**Texas HIV Medication Program, ATTN: MSJA, 1100 W 49th St, Austin, TX 78756** **(05/2004)**